elects its own officers and reviews all subjects and candidates expected to come before the House of Delegates for action or election. A unit rule is not used; each delegate is a free agent. Ordinarily there is almost complete unanimity of opinion in the delegation, both as to business and to candidates for office, but there is no stigma attached to minority opinions or independent actions by individual members.

All delegates and alternates are given assigned duties during the A.M.A. sessions and are expected to carry out their assignments and report on them to the entire delegation.

By following these procedures over a period of years, the California delegation has become known in the A.M.A. as a most highly effective and respected group. By choosing qualified candidates in the first place, by providing for the education of the alternate delegates, by advancing the alternates to delegates when vacancies occur and by operating on a business basis during the A.M.A. sessions, the California delegation has attained its present stature in the A.M.A. The most eloquent recognition of this position is that many other state delegations have followed California's lead in the effective choice of representatives, in the education of them and in organization of their efforts.

SAMUEL R. SHERMAN, M.D.
Chairman of the Council

The "Fiery Trial" of Private Practice

Report of the Commission on Medical Services

MR. SPEAKER, AND MEMBERS OF THE HOUSE OF DELEGATES:

We are just beginning a decade that many economists believe promises prosperity and unparalleled economic development. This decade may well prove the most eventful in the history of private medicine, and one in which events will decide whether the practice of medicine will survive as we have known it, or collapse.

Already we are approaching a crossroads at which decisions must be made that will affect us all. There is every indication that forces and pressures outside medicine will soon accept or reject the voluntary approach to meeting the costs of medical care and the methods by which that care is delivered or received.

Social evolution and changing economic conditions are clearly reflected in all walks of life. The growth pattern of the attitude of the public regarding medical care can best be shown by a historical résumé of both national and state actions.

Congress first entered the field of health care in 1798 when the United States Marine Hospital Service was started. By 1929 expenditure of public money for medical care, excluding funds for medical facilities, amounted to $414 *million.* In 1958 it was $4.9 *billion.* To these amounts add the private expenditures for this purpose: in 1929, $3 billion; in 1958, $16.7 billion. A total of nearly $22 billion is now being spent annually on health and medical care—about one-fourth of this total by federal, state and local government units.

The degree of change and the relative emphasis upon the problems of medical care have varied directly with the intensity of social and economic ferment.

As we enter this period of acclerated change, it is well to recall that the present urgent and immediate probems of medical care are not new.

On previous occasions, this House of Delegates has faced issues similar in magnitude to those we are discussing at this Annual Session. Today we are facing the issue of government medical care as a social benefit—Forand-type legislation, for example. However, even before World War I there was agitation for—and opposition to—compulsory or voluntary systems of medical care insurance.

The main events and development of issues in the past 42 years are best emphasized by dividing the time into three periods: 1910-1920; 1921-1933; and 1933 to the present.

1910 TO 1920

In the first period of sporadic thought about medical care programs, plans reached the legislative stage in several states, but no bills of this order were passed except those setting up workmen's compensation. (In California, a Workmen's Compensation Act was passed in 1912.)

1921 TO 1933

The second period was a quiet one devoted to the study of basic facts only superficially comprehended in the first period. It was during this period that the famous "Committee on the Cost of Medical Care," with Doctor Ray Lyman Wilbur of California as its chairman, was established. This committee released a total of 28 reports on health matters between 1928 and 1932. The final report of that group, and the reactions to it, form the base for the third period of the compulsory versus voluntary medical care insurance movement.

1933 ON

The third period has been characterized by actions on a much broader base of support and opposition and a profoundly different social, political and economic setting.

National Activities

On the national scene, events moved rapidly. In 1933 federal regulations were adopted defining the policies and procedures under which medical care might be given to persons receiving unemployment relief.

1934 . . . The President established a "Committee on Economic Security" to study the effects of ill health and other misfortunes.

1935 . . . The Social Security Act was passed.

1936 . . . The first compulsory health insurance bill was introduced in Congress, and the first "National Health Survey" was completed.

1937 . . . The second compulsory health insurance bill was introduced.

1938 . . . The President called a "National Health Conference" following receipt of the report of his "Interdepartmental Committee to Coordinate Health and Welfare." The third special session of the A.M.A. House of Delegates was called to establish clearly the attitude of organized medicine on the proposed Federal Government program.

1939-1947 . . . A total of seven bills were introduced in Congress, nearly one each year, calling for compulsory health insurance programs.

1948 . . . Another National Health Conference and again a recommendation for a compulsory health insurance system—this time by Oscar Ewing, Federal Social Security Administrator.

1949 . . . Bills in Congress on medical care became so numerous that keeping track of them was almost impossible.

1951 . . . The establishment of the President's Commission on Health Needs of the Nation. (It reported in 1953.)

1956 . . . Congress provided medical care for military dependents—Medicare.

1957 . . . Congress amended the Social Security Act to provide medical care for public assistance recipients.

I am sure you are familiar with events of the past two years.

The third period of the medical care insurance movement in the United States is by no means over.

Activities in California

While these events were taking place on the national scene, what about California and the California Medical Association? What events, and what actions by this House of Delegates, have led us to our present position as we enter the 1960s?

1910 TO 1920, THE FIRST PERIOD

In California, the C.M.A. refused to participate in the development of our Workmen's Compensation Law passed in 1912. Today we negotiate the fee schedule—piecemeal—with a politically appointed body.

In *1917*, our State Legislature received a report of its Social Insurance Commission which recommended compulsory health insurance; but a constitutional amendment designed to implement it in 1918 was defeated.

1921 TO 1933, THE SECOND PERIOD

1929 . . . Two meetings of the Council of the California Medical Association were devoted to considering plans for a medical care program.

1930 . . . The Graves Report to the Council of the California Medical Association, recommending a program for persons earning $2,500 or less.

1933 ON, THE THIRD PERIOD

1933 . . . The State Legislature appointed a committee to report at the next regular session on the advisability of a Health Insurance Act. At its annual meeting that same year, the C.M.A. House of Delegates instructed the Council to parallel the work of the Legislature's committee.

1934 . . . The Council reported to the House of Delegates that it favored a voluntary service type plan, rather than a compulsory one, for the people of California and recommended continuation of its study. The reference committee reviewing the Council report said:

"We agree with the Council that legislative establishment of health insurance in California would be undesirable at this time from the standpoint of the public and the profession, but we earnestly believe that if such legislation appears inevitable to satisfy the economic demand of the times, the C.M.A. should be prepared to cooperate in molding this legislation in such a manner as to preserve as nearly as may be the standards of scientific service of professional relations which are of such vital importance to the community. We cannot, however, refrain from endorsement of the fundamental principle contained in the report of the Council. We believe that perhaps the most effective means of avoiding ill-advised legislative establishment of health insurance is to offer to the community a solution of the problem on our own initiative. We believe that there are two definite lines of activity in which this Association should now engage. One, offer the community a solution of the problem in the form of a voluntary payment plan set up by this Association. Two, as recommended by the Council, adequately prepare to cooperate with preparation of legislation, if such becomes inevitable, establishing a compulsory payment plan. We believe it is

feasible to set up a voluntary plan to be operated by this Association that would later fit into a compulsory payment plan which may be established by legislative enactment."

At that same session, the House of Delegates also established a special "Committee of Five," instructing it to conduct a survey of the problem as it applies to California and to formulate a plan for the administration of health insurance and to prepare a bill for suitable legislation which would be available for presentation in the 1935 session of the State Legislature. The "California Medical-Economic Survey" had its inceptions in those actions of the House of Delegates in May, 1934.

1935... On March 2 and 3, the first special session of this House of Delegates was called to consider the preliminary report of the "Committee of Five." This report contained two phases:

1. Establishment of a voluntary service plan by the Association rather than approve the establishment of compulsory health insurance.

2. Following instruction of the 1934 House of Delegates, to prepare a draft of a bill for compulsory health insurance.

By a vote of 63 to 48, this House of Delegates rejected the recommendation to establish a voluntary service plan and adopted a resolution approving cooperation with the legislature and the proposed compulsory health insurance bill.

A special committee called the "Committee of Six" was established and authorized by this House of Delegates to draft a form of compulsory health insurance act to be submitted to the California Legislature which was in session that year. This was done and the proposed law was presented to the Legislature of 1935 as Senate Bill 454 and its companion Assembly Bill, 1097. But neither bill was passed.

1938... Democrat Culbert L. Olsen was elected Governor along with a strong democratic legislature. Because he was known to favor compulsory health insurance, and in light of pending federal legislation and the attitudes of the Farm Bureau, organized labor and others, the Council called the second special session of this House of Delegates on December 17 and 18. At that meeting, this House voted 101 to 4 to authorize the creation of California Physicians' Service, the first statewide plan of its type, with an income ceiling of $3,000. In so doing, this House completely reversed the position it had taken less than two years previously. It recognized a need which had to be met and took positive steps to meet it.

1939... At the January 14 Council meeting, the final phases of the newly created health plan were completed and the name California Physicians' Service was formally adopted.

Governor Olsen introduced his compulsory health insurance measure which, after a long debate in the Assembly was defeated, by a 2 to 1 vote. The formation of C.P.S. had already had its first effects on state and national legislation.

C.P.S. was legally established on February 2, 1939 by the C.M.A. as a nonprofit corporation falling under the jurisdiction of Section 593A of the California Civil Code. Doctor Ray Lyman Wilbur was elected its first president, and a loan of $15,000 was provided by the C.M.A. to cover initial expenses. Thus, for the first time in the nation's history, a statewide, medically-sponsored, voluntary, nonprofit, prepaid health plan had been organized by the medical profession to meet a great social need. By December 31 of that year, (1939) C.P.S. had a subscriber membership of 5,742 people and a participating physician membership of 5,000. The C.M.A. membership at that time was 6,401. At the close of 1959 there were 781,281 subscribers, 14,300 participating physicians, and a C.M.A. membership of 16,511.

1941-1942... Measures similar to that of Governor Olsen were introduced in the 1941 and 1942 sessions of the Legislature, but died in committee without a hearing.

1942... Permanente Health Plan was started.

1944... On December 13, Governor Earl Warren, meeting with the C.M.A. Council, stated his intention to introduce a compulsory health insurance measure in the 1945 legislature and requested the C.M.A. to inform him as to the type of plan the Association would approve. On December 29, he announced his intent in the press. The third special session of the C.M.A. House of Delegates was held January 4-7, 1945.

At that meeting, this House of Delegates reemphasized its belief in the voluntary service plan and rejected Governor Warren's proposal. The fight was on, and with only a handful of organizations supporting the California Medical Association in its opposition, Warren's proposal and that of the CIO were defeated—but this time by a margin of one vote (39-38) in the Assembly.

1946... This House of Delegates received the Chandler Committee Report, recommending that C.P.S. pay all physicians the same fee, that osteopathic physicians be paid, and that strong support be given to C.P.S. This House approved those recommendations.

1947... Governor Warren reintroduced his health insurance bill and again it was defeated.

1949... Governor Warren again reintroduced his health insurance bill, and it was defeated again.

The C.P.S. income ceiling was raised from $3,000 to $3,600. C.P.S. had proven its political value.

1951 . . . C.P.S. paid, for the first time, 100 per cent of its fee schedule.

This House of Delegates established the C.P.S. Study Committee and raised the income ceiling to $4,200.

By this time, four and a half million people in California were covered by some form of voluntary health insurance (821,975 under C.P.S.). The state's population at the time was nearly 11 million.

1952 . . . The C.P.S. Study Committee presented its report to the House of Delegates and recommended an "average fee plan." A report by Ernest Dichter, Ph.D., who had done a study of the structure, function and effect of C.P.S., and a survey of C.P.S. by Wolf-Cochran and Linder were presented.

The terms "personal physician," "Robin Hood concept of fees" and "biological blackmail" came into being.

This House of Delegates formed the Commission on Medical Services "whose function shall be to study, keep records upon and recommend action to the C.M.A. and its correspondent bodies on all types of prepaid medical care, including C.P.S., insurance company plans, Industrial Accident Commission schedules, Union Labor plans, compulsory governmental and nongovernmental plans."

The House "Committee of Eight" reported on its efforts to develop a better fee schedule for C.P.S. That report was rejected, as the "Fry Committee" report of the previous year had been.

1953 . . . At the Interim Session of this House of Delegates on December 2 and 3, 1953, the Commission on Medical Services recommended the adoption of the "Usual Fee Indemnity Plan," and reported on its efforts to work out adjustments in the C.P.S. fee schedule. In its report at that time the Commission said: "Throughout these discussions, the Commission has steadfastly maintained that determination of relative values of fee schedule items is a prerogative of doctors alone, which they must jealously guard."

The Council approved the establishment of a subcommittee on Principles of Fee Schedules (later changed to Committee on Fees) to formulate principles for establishing fee schedules.

1954 . . . This House of Delegates authorized the C.P.S. $6,000 income ceiling on a county option basis.

The First Relative Value Study was begun by the Committee on Fees.

1956 . . . By this time approximately 30 per cent of the total United States medical expenditures was being financed by government, local, state or national.

Medicare was under consideration in Congress, and the C.M.A. Council created the Committee on Government Financed Medical Care.

The Relative Value Study was published.

1957 . . . Medicare and Public Assistance Medical Care programs were put into effect.

A revised edition of the Relative Value Study was published.

1958 . . . The House of Delegates ordered revision and updating of the Relative Value Study. And also in that year:

- Total public and private spending on health and medical care was nearly 25 billion dollars.
- Forand Bill introduced in Congress.
- C.P.S. C Schedule, for $7,200 income ceiling, was developed at request of the county societies.
- There were 14,639,000 people in California, 16,000 members of C.M.A., 780,000 people covered by C.P.S., and 14,300 participating C.P.S. physicians.
- 123 million Americans were protected against expenses of hospital care; more than 111 million against surgical expense; over 75 million against regular medical expense and more than 17 million had major medical expense insurance.

1959 . . . The California legislative auditor froze all fees paid by the state at a factor of 4 for the unit value of the Relative Value Study.

County societies approved letting C.M.A. officials use regional data from the 1958 Relative Value Survey in dealing with state government.

The Federal Employees Benefit Act was passed by Congress.

An Assembly interim committee began a study of the cost of hospitalization and medical care.

1960 . . . Governor Brown established a "Committee on Medical and Health Needs of California" which is to submit a report by November.

The question of extension of medical care as a benefit of Social Security is to be resolved in the Congress.

Since 1940, private health insurance plans have developed rapidly as alternatives to governmental programs. Giving impetus to this growth was the war-time wage stabilization program and its encouragement of medical care programs as a fringe benefit. The continuing postwar emphasis on health and welfare plans, coupled with management's increasing concern for human relations in industry, has brought about the marriage of medical care and industrial relations with a result that today the union-administered health and welfare plans represent a force of equal magnitude to that of government.

Nearly three-fifths of the 123 million people who now have some kind of prepaid health insurance have it as a part of an employee benefit plan that is paid for in full or in part by their employers, who are now contributing about a billion dollars a year.

In the dynamic social structure of our society, the new public attitudes toward medical care stem partly from the growing health-consciousness of the American people, partly from their increasing familiarity with medical potential, and partly because more people today are directly experiencing the benefits of the scientific revolution in medicine than ever before. These attitudes also stem from more education, higher incomes and greater mass purchasing power and are reflected in the fact that an increasing number of people appear to have adopted the view that adequate medical care is as much implicit in the right to life, liberty and the pursuit of happiness as is public education.

The medical profession and the public today both face the question: How can the principles of prepayment of medical costs be maintained and how can the funds made available thereby be best distributed or used to insure the maximum benefits to the majority of the public. Physicians must decide once and for all where they fit into this picture—particularly in view of the fact that physicians do not control the national economy and the total number of physicians in this country constitutes only one-tenth of 1 per cent of the voting population.

If the medical profession fails to meet its obligations, forces outside of medicine will regulate medical practice and its cost.

I would like to conclude this historical résumé by quoting from the utterances of one of this nation's great men in a time of crisis. Addressing the Congress in the gloomy autumn of 1862, Abraham Lincoln began: "Fellow citizens, we cannot escape history. We of this Congress and this Administration will be remembered in spite of ourselves. No personal significance or insignificance can spare one or another of us. The fiery trial through which we pass will light us down, in honor or dishonor, to the last generation."

Respectfully submitted,

FRANCIS J. COX, M.D., *Chairman*
Commission on Medical Services

In Memoriam

BACON, EDISON PIERCE. Died February 18, 1960, aged 52. Graduate of University of Southern California School of Medicine, Los Angeles, 1940. Licensed in California in 1940. Doctor Bacon was a member of the Los Angeles County Medical Association.

✤

FIESE, MARSHALL J. Died in Bakersfield, March 1, 1960, aged 43, of injuries received in a train wreck. Graduate of Stanford University School of Medicine, Stanford-San Francisco, 1944. Licensed in California in 1944. Doctor Fiese was a member of the Fresno County Medical Society.

✤

GARDENIER, WILLIAM H. Died in South San Gabriel, February 22, 1960, aged 49, of heart disease. Graduate of Stanford University School of Medicine, Stanford-San Francisco, 1935. Licensed in California in 1935. Doctor Gardenier was a member of the Los Angeles County Medical Association.

✤

GOODMAN, EPHRAIM FRANK. Died in Downey, February 10, 1960, aged 54, of heart disease. Graduate of University of Illinois College of Medicine, Chicago, 1933. Licensed in California in 1942. Doctor Goodman was a member of the Los Angeles County Medical Association.

✤

HERRICK, FRANK LESLIE. Died November 12, 1959, aged 71. Graduate of Oakland College of Medicine and Surgery, California, 1912. Licensed in California in 1912. Doctor Herrick was a member of the Alameda-Contra Costa Medical Association.

KONIGMACHER, ADAM H. Died November 20, 1959, aged 69. Graduate of Creighton University School of Medicine, Omaha, Nebraska, 1913. Licensed in California in 1920. Doctor Konigmacher was a retired member of the Fresno County Medical Society and the California Medical Association, and an associate member of the American Medical Association.

✤

LATON, GEORGE PEAVY. Died February 10, 1960, aged 75. Graduate of Dartmouth Medical School, Hanover, New Hampshire, 1909. Licensed in California in 1918. Doctor Laton was a life member of the Los Angeles County Medical Association.

✤

SEGAL, ROBERT. Died in Mar Vista, February 20, 1960, aged 49. Graduate of Tulane University School of Medicine, New Orleans, Louisiana, 1933. Licensed in California in 1935. Doctor Segal was a member of the Los Angeles County Medical Association.

✤

SIDERS, RICHARD C. Died in Redwood City, February 7, 1960, aged 49. Graduate of Northwestern University Medical School, Chicago, Illinois, 1943. Licensed in California in 1945. Doctor Siders was a member of the San Mateo County Medical Society.

✤

SUMNER, WILLIAM ARTELL. Died in San Francisco, February 17, 1960, aged 59. Graduate of Stanford University School of Medicine, Stanford-San Francisco, 1930. Licensed in California in 1930. Doctor Sumner was a member of the San Francisco Medical Society.